Beneficiaries Protections – Cindy Robertson

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BENEFICIARY PROTECTIONS: MLTSS PRE-IMPLEMENTATION RECOMMENDATIONS

- Make clear in State statute the mandate to implement a Medicaid MLTSS system, including model options.
- Bring State Medicaid eligibility determinations, including re-determinations, into compliance with federal law timeliness requirements, 45 days for individuals age 65 or older and 90 days for individuals whose eligibility is based on disability.
- Bring all required State LTSS facility licensing and certification up to date.
- Stabilize cross-DHHS systems to ensure that all currently enrolled and engaged Medicaid LTSS providers meet all licensing, certification, and credentialing requirements.

BENEFICIARY PROTECTIONS: MLTSS PRE-IMPLEMENTATION RECOMMENDATIONS

- As much as possible, finalize as many outstanding State Medicaid fair hearing procedures related to MLTSS prior to the conversion from fee-for-service to MLTSS.
- Re-establish and further develop a DHHS focus on elder and adult services that is led by someone with experience and expertise in HCBS services for elders and adults with physical disabilities. Also staff this effort with experienced personnel.
- Amend CFI service rules to make clear the standard of coverage for each service. Include in rules a clear and safe transition process for recipients transitioning from nursing home to a home and community-based setting included in the CFI program.

BENEFICIARY PROTECTIONS: MLTSS PRE-IMPLEMENTATION RECOMMENDATIONS

- Amend the CFI 1915(c) waiver application to reflect managed care implementation.

- Assess, stabilize, and develop a monitoring system for the State's LTSS infrastructure, both the Medicaid and non-Medicaid infrastructures. The State should:
  - Assess: causes and impact of provider losses on Medicaid and non-Medicaid populations; LTSS needs and desired services of elder and adult populations; and capacity of the pre-MCE infrastructure.
  - Work to stabilize the needed LTSS services infrastructure; and
  - Develop a system to monitor needs for and capacity of this infrastructure over time, with a goal of not only sustaining, but also improving capacity and quality.

BENEFICIARY PROTECTIONS: MLTSS PRE-IMPLEMENTATION RECOMMENDATIONS

- Define roles of the State and MCE in workforce development.
- Develop and vet a rigorous State MLTSS monitoring system manned with a sufficient number of experienced personnel.
- Promulgate administrative rules on:
  - The MCE process for implementing the NH RSA 151-E:11 average annual aggregate cost limits in the CFI care plan authorization process;
  - The process an MCE must follow to assess proposed CFI care plan budgets that exceed 80% of nursing facility costs; and
  - Standards for exceeding nursing facility costs in a care plan.

BENEFICIARY PROTECTIONS: MLTSS PRE-IMPLEMENTATION RECOMMENDATIONS

- Identify the role of the medical home in MLTSS and the overall goals relative to the medical home for LTSS populations.

- Perform and present an analysis of the opportunities in the various managed care models or combination of models with a recommendation for the best model for New Hampshire.

  Include the intended value, quality, efficiency, innovation, and savings expected. Include the savings rendered in Step 1, as well as the expected savings from MLTSS (CFI & nursing facility) and the expected source(s) of those savings.

- Perform and present an impact analysis of Federal Medicaid managed care rules released in May 2016.

BENEFICIARY PROTECTIONS: PARTICIPANT SAFETY

- An acuity-based utilization management process, as found in standard health insurance plans, should not drive MLTSS.
- Ensure applicants, recipients, and providers ready access to a full list of available MLTSS service coverage, as well as a description of those services and standards for service authorization.
- Minimize disruption in service plan transitions through strong continuity of care standards that provide for continuous access to needed services and to providers with whom the applicant/recipient has a relationship, as well as safety measures in the event unintended disruptions occur.

BENEFICIARY PROTECTIONS: PARTICIPANT SAFETY

- The State should retain the responsibility to:
  - Determine nursing facility level of care; and
  - To perform PASRRs.

- Recognize that a routine provision of LTSS sometimes results in a recipient no longer demonstrating a nursing facility level of care, but the recipient may still need LTSS to maintain such a status.

- Subject to the LTSS infrastructure assessment and development of an infrastructure monitoring system, establish LTSS network adequacy standards that reflect the needs, preferences, and existing provider relationships of recipients. Ensure availability of a broad range of LTSS and maximize choice of providers.

BENEFICIARY PROTECTIONS: PARTICIPANT SAFETY

- Ensure recipients requiring a nursing facility level of care have a true medical home. Such a medical home is more than a mere assignment to a primary care provider (PCP).
- Establish, through a public process, a risk protocol to which each MCE must adhere – including:
  - The risk the recipient may undertake under a person-centered care plan process; and
  - The level of risk a recipient must accept as a result of service authorization by an MCE.
- Require MCE establish an LTSS consumer advisory committee.
- The State should continue to oversee critical event and incident reporting.

BENEFICIARY PROTECTIONS: ENROLLMENT & DISENROLLMENT

- DHHS work with stakeholders, including Medicaid recipients, to:
  a. Develop the LTSS beneficiary support system required under Federal law;
  b. Define time required for the average New Hampshire LTSS recipient to make an informed, active MCE choice;
  c. Develop standard for auto-assignment of LTSS recipients who do not make an active MCE choice; and
  d. Explore and establish all LTSS-related reasonable bases for disenrollment for cause.

- Ensure MCAC has sufficient time to thoughtfully review and provide meaningful comment on MCE handbooks and other marketing materials.

BENEFICIARY PROTECTIONS: ENROLLMENT & DISENROLLMENT

- Publish an annual report card on MCEs that includes MCE quality and performance indicators, including consumer satisfaction, to assist applicants/recipients in choosing an MCE.

- Initiate MLTSS enrollment concurrently with the initiation of an annual enrollment period.

BENEFICIARY PROTECTIONS: CASE MANAGEMENT

- Maintain independent targeted case management, as currently practiced, as the preferred standard for the service.

- Clearly distinguish MCE care coordination from targeted case management. Include in the distinction:
  - The actors for each task and their qualifications;
  - Whether the service is voluntary or mandatory for the recipient;
  - The role of the primary care provider in each process; and
  - The long-term goals of the program, i.e., that care coordination become part of the primary care provider office within a medical home model.

BENEFICIARY PROTECTIONS: CASE MANAGEMENT

- Require that the CFI case management supervisor be a registered nurse with at least three years experience in case management and an additional two years in LTSS for older adults and working age adults with disabilities.
- Establish staffing ratios that reflect current best practices. Of particular note, recipients in small residential care setting (i.e., settings licensed under He-P 804) should be treated as living in their own home.
- Establish a maximum, formula-based weighted value on individual case manager caseloads. The formula should consider acuity and function of the recipient. Vet the formula through a public process.

BENEFICIARY PROTECTIONS: CASE MANAGEMENT

- Require and provide person-centered training for all case managers.

BENEFICIARY PROTECTIONS: OFFICE OF OMBUDSMAN

- The CFI ombudsman should be independent of both the State and the MCE, as recommended by NASUAD in its October 4, 2017 presentation to the SB 553 Workgroup.
  - Viewed by recipients and applicants as— truly independent, free from outside influences, and above-reproach.
  - Housed in an independent organization that has an established record of providing representation for Medicaid LTSS participants. (Consider a MLTSSO similar to the Wisconsin, operated by the Wisconsin Protection and Advocacy office.)
- An ombudsman should have on-the-ground expertise in home and community-based LTSS.

BENEFICIARY PROTECTIONS: OFFICE OF OMBUDSMAN

- An ombudsman should provide CFI applicants/recipients with:
  - Outreach and education about their rights and responsibilities;
  - Information, referral, and direct assistance in their dealings with the MCEs, providers, and the State;
  - Assistance navigating the program, including: making enrollment decisions; understanding benefits, coverage, and access rules and procedures; exercising rights and responsibilities; accessing covered benefits; resolving billing problems; navigating grievance, appeal and fair hearing processes; raising and resolving quality of care and quality of life issues; ensuring the right to privacy, consumer direction, and decision-making; and understanding and enforcing the individual's civil rights.

BENEFICIARY PROTECTIONS: OFFICE OF OMBUDSMAN

- An ombudsman should provide the State with:
  - Objective monitoring and oversight of the MLTSS program;
  - Assistance in identifying and resolving systemic issues; and
  - Regular reports relative to its activities.
- Ombudsman reports should be made public.
- The ombudsman should be accessible to applicants/recipients by phone and, when appropriate, in-person appointments.
- The MCE should notify recipients of the availability of the ombudsman in the member handbook, as well as annual notices summarizing grievance and appeal procedures and notices of adverse benefit determinations.

BENEFICIARY PROTECTIONS: OFFICE OF OMBUDSMAN

- The ombudsman should have established channels of access to senior administrators at the MCE and the State. A schedule of periodic meetings between these parties should be required to discuss trends and systemic issues.

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- For ease of access to recipients and their representatives, compile all grievance, appeal, and fair hearing requirements in a State administrative rule.

- To lessen burden, make a more understandable process, and structure a more meaningful data resource, the State should:
  - Issue a uniform description of the grievance, appeal, and fair hearing process to be used in each MCE handbook;
  - Require uniform grievance and appeal procedures, notices, and forms across MCEs and fee-for-service populations; and
  - Require a self addressed and stamped return envelope be sent with each MCE notice of adverse benefit determination (ABD).

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- MCE handbook information on grievance, appeal, and fair hearing should include:
  - Definitions and examples of each process;
  - The standard for recovery for continued benefits when the final decision is adverse to the recipient; and
  - The contact information for free assistance in filing and navigating the processes.
- The State should educate MLTSS providers on grievance and appeal procedures.
- The State should rigorously monitor MCE grievance and appeals processes.

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- Require recipients and providers have immediate full access to clinical or coverage guidelines used and/or referred to by an MCE when making the ABD.

- In addition to Federal standards, deemed exhaustion of the MCE appeal process should include the following circumstances:
  - Notice provided in a manner that does not incorporate necessary translation or alternative formats;
  - Notice not written at an appropriate reading level; or
  - Notice does not offer auxiliary aids and services free of cost during the appeal.

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- Give the recipient a voice in when and where an appeal or fair hearing takes place, as transportation for these is not a covered service and the recipient may not have the means to get there. Include participation by phone and/or an in-home process.
- When a provider or authorized representative files a request for an appeal or fair hearing, the decision maker should provide notice of decision not only to the provider or authorized representative, but also to the recipient.

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- With the current length of the State fair hearing process—
  - The State should offer an external review when LTSS fair hearing requests involve: (1) an ABD; (2) the recipient completed the MCE appeal process; (3) the recipient submitted the request for external review within 30 days of the MCE's appeal decision; and (4) the recipient requested a continuation of benefits, which would be subject to recovery pursuant to State standards on recovery and the recipient could not reasonably be expected to be able to repay the cost of those benefits within 6 months of the final decision.
  - Allow the LTSS recipient appealing an ABD, to jointly file an appeal and a request for a fair hearing at the same time, to start the clock for both and lessen the time to a final decision.

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- Relative to continuation of benefits, pending a "final decision:"
  - Establish clear State standards on recovery of benefits rendered pending an appeal or fair hearing decision and require MCEs comply with these standards.
  - Make clear that recovery is from the recipient, not the service provider.
  - Prohibit recovery when the appeal is not frivolous and rendered on legitimate grounds. Consider: the recipient's circumstances and expectations in the period prior to the ABD; the duration of the appeal and fair hearing process that is beyond the recipient's control; and the chilling effect of an overly severe recovery standard on the recipient's decision to appeal or seek a fair hearing.

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- Relative to continuation of benefits, pending a “final decision” (continued):
  - The State should notify the MCE when one of its recipients requests a State fair hearing and continued benefits, so as to ensure no disruption of benefits.
  - The State should make clear that services should be covered retroactively when the appeal/fair hearing recipient does not request a continuation of benefits and the adverse determination is overturned at appeal or fair hearing.

Note: A “final decision” is the last decision rendered on an adverse benefit determination, whether it is the MCE appeal decision, the fair hearing decision, or a judicial decision.

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- The State should define the following discretionary standards required in Federal law (42 CFR part 438):
  - "Failure to provide services in a timely manner" (438.400(b));
  - Circumstances under which recipient may be required to pay costs of continued benefits rendered pending the final decision of an appeal, fair hearing, and/or judicial action (§§ 438.404(b) & .420(d));
  - Timeframe in which MCE must send a notice of ABD, relative to a standard service authorization decision that denies or limits services (§ 438.404(c));
  - Timeframe and format in which the MCE must acknowledge receipt of an appeal (§ 438.406);

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- Allowance for recipient's provider or authorized representative to file appeal of an ABD, with written consent of recipient. Also, require MCE notify provider or authorized representative that recipient alone may request continuation of benefits (§ 438.402(c)(1)(ii));
- Required clinical expertise for MCE decision makers on appeals in which denial is based on lack of medical necessity or appeal involves clinical issues (§ 438.406);
- Timeframe in which MCE must inform recipient of limited time available to present evidence and testimony and make legal and factual arguments in appeal process (§ 438.406); and

BENEFICIARY PROTECTIONS: GRIEVANCE & APPEALS

- Timeframe in which MCE must provide recipient access to his/her case file and any new or additional evidence considered, relied upon, or generated by or at the direction of the MCE in connection with the appeal of the ABD (§ 438.406);
- Timeframes in which MCE must resolve a grievance or appeal and provide notice, relative to standard or expedited resolution of appeals, as well as allowable extensions of these (§§ 438.408 & .410); and
- State policy on payment for services, if MCE or State reverses decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending (§ 438.424(b)).

BENEFICIARY PROTECTIONS: TRANSITION, NF TO HCBS

- Promulgate administrative rules on applicant/recipient transitions from nursing facility services to home and community-based care services.
- Prohibit the MCE from denying coverage for nursing facility care or forcing a transition from nursing facility to home and community-based care to the applicant/recipient otherwise meeting the State eligibility criteria for such care.
- To ensure the recipient an informed decision on transition and to timely initiate a key relationship, ensure assignment of a CFI case manager to the recipient for the entire transition process, starting with the initial transition election discussion(s).

BENEFICIARY PROTECTIONS: TRANSITION, NF TO HCBS

- In a transition from nursing facility to home and community-based care, the State should assist with the first month rental and initial food costs, when cost effective and not otherwise covered under public programs. Costs for transportation to view potential rentals and transact rental agreements, while the applicant/recipient is still living in the nursing facility, should also be covered.